

OPEN ENROLLMENT 2010 Summary of Benefits
Your Health Benefits for SmartSuite

Hamilton County

OPEN ENROLLMENT HOTLINE • 1-888-393-6765



HUMANA
Guidance when you need it most

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If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting **Humana.com** and clicking the Privacy Practices link at the bottom of the home page
- E-mailing us at privacyoffice@humana.com
- Sending a written request to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202

A guide to your healthcare coverage

what's *inside*

Throughout this guide, you'll find lots of information to help you choose and use your plan:

Step 1 – know what you need

Before you choose your benefits, take a few minutes to find out what kind of healthcare coverage you want and need. Thinking about how you'll use your plan is the first step in choosing with confidence.

Step 2 – explore your options

After finding out about your needs, it's time to see what fits them. The plan information in this section explains what's available to you, why you might want it, and how it works.

Step 3 – choose and use your plan

Now you're ready to roll – or enroll! This section describes the resources available to help you choose a health benefits plan. It also gives you some tips on using the plan you select.



Step 1

know what you ***need***

Before you choose your benefits, take a few minutes to find out what kind of healthcare coverage you want and need. Thinking about how you'll use your plan is the first step in choosing with confidence.

Step 1

know what you need

Are you looking for something practical and economical ... or something sporty with lots of extras?

One size doesn't fit all. That's why you have so many choices at the car lot and the grocery store. It's also why your employer is giving you a choice of health benefits, so you can "shop" for one that meets your unique requirements.

Sorting through the options takes some effort, though. Before you bought your last car, it's likely you spent hours – maybe days – thinking about:

- What you want – red or black, domestic or import?
- What you need – SUV or sports car, safety features or speed?
- How much you're willing to spend – economy car or lots of features?

When you choose a health plan, it may take an hour or more to find the right balance of features and cost – but it's worth the time. After all, your health plan choice affects you, your family, and your cash flow for a long time.

What will provide the right amount of coverage for you and your family?

When choosing a health benefits plan, knowing what you spent in the past makes it easier. The planner on the next page can help.

Gather your medical expense records – your calendar, checkbook, receipts, and Explanation of Benefits (EOB) summaries – to see the services you received and how much you paid for copayments, deductibles, and coinsurance.

What options do you need to look at?

To weigh your options, you have to know what they are. Here are some terms you may see as you compare plans.

- **Copayment** – The amount you pay when you receive medical care or a prescription drug. It varies depending on your plan and the services you receive. Copayments do not apply to annual limits, like your deductible and out-of-pocket maximum.
- **Deductible** – The amount you pay toward certain medical expenses before your plan starts paying its share of the costs. Except for copayments, most of your expenses accumulate toward the deductible.
- **Coinsurance** – A set percentage of the total cost you must pay for your medical or dental services or prescription drugs. For example, if your coinsurance is 70/30, once you meet your deductible, your plan pays 70 percent and you pay 30 percent.
- **Out-of-pocket maximum** – The limit, or ceiling, on your costs for medical care within the plan year. As you use medical services, much of what you spend counts toward your maximum. Once you reach the limit, your plan pays 100 percent of covered services. You continue to pay copayments if your plan includes them.

Step 1

know what you need

Do you put lots of miles on it ... or does it sit in the garage?

This diary gives you a general idea of how much you spent on healthcare during the previous plan year. In general, you have two kinds of costs:

1. Premiums stay the same whether you use healthcare or not.
2. Out-of-pocket costs vary depending on your healthcare usage later.

With many types of plans, if your premium is higher, you have lower out-of-pocket costs when you receive care ... and vice versa.

1. How much did you pay in premiums?

Total annual payroll deduction for your premium (Amount each paycheck x pay periods per year)	\$
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2. How much did you and your family pay in out-of-pocket costs like copayments, deductible, and coinsurance?

Service	Your Cost	x	Number of Visits	=	Total
Primary care visit	\$	x		=	\$
Specialist visit	\$	x		=	\$
Urgent care	\$	x		=	\$
Emergency room	\$	x		=	\$
Hospital	\$	x		=	\$
Deductible (enter amount you actually paid toward the deductible)					\$
Coinsurance (enter the amount you actually paid)					\$
Prescription Drugs	Your Cost	x	# of Times Filled	=	Total
	\$	x		=	\$
	\$	x		=	\$
	\$	x		=	\$
	\$	x		=	\$
Over-the-Counter Drugs	Your Cost	x	# of Times Purchased	=	Total
	\$	x		=	\$
	\$	x		=	\$
	\$	x		=	\$
	\$	x		=	\$
Vision, Dental, Hearing, Chiropractor, Etc.	Your Cost	x	# of Times	=	Total
	\$	x		=	\$
	\$	x		=	\$
	\$	x		=	\$
	\$	x		=	\$
Grand Total					\$

Step 1

know what you need

Will your needs change?

When choosing a plan, also consider what you'll need in the future. This chart lists estimated charges for different types of office visits, as well as other services you might have during an office visit.* In addition to routine healthcare, think about whether you or anyone your plan covers is expecting something this year, like surgery or pregnancy.

Keep in mind...

You'll pay a smaller share of your costs when you go to in-network providers – doctors, facilities, and other providers who offer discounted rates for Humana members. And if you go out-of-network:

- You may pay toward a separate deductible
- The provider may bill you for amounts not covered by your plan

Procedure	Average Cost*
Office Visits	
New Patient (10 minutes)	\$42
New Patient (60 minutes)	\$140
Established Patient (10 minutes)	\$38
Established Patient (60 minutes)	\$182
Doctor Visits – Preventive Care	
Initial comprehensive visit; new patient (infant under one year)	\$89
Initial comprehensive visit; new patient (between ages 1-64)	\$106
Initial comprehensive visit; new patient (65 years and over)	\$109
Periodic comprehensive visit; established patient (infant under one year)	\$70
Periodic comprehensive visit; established patient (between ages 1-64)	\$90
Periodic comprehensive visit; established patient (65 years and over)	\$98
Mammography	
Computer-aided detection with physician explanation; diagnostic mammogram	\$21
Diagnostic mammography, bilateral	\$115
Computer-aided detection with physician explanation; screening mammogram	\$21
Screening mammography, bilateral	\$103
Ultrasound	
Ultrasound, first trimester	\$174
Laboratory Services	
Lipid panel	\$15
Automated hemogram (blood work) with automated differential white blood cell count	\$21
Automated hemogram	\$25
Immunization	
Immunization fee; first injection	\$14
Flu vaccine; 3-35 months old	\$14
Flu vaccine; 3 years old and above	\$14
Allergy Testing	
Tests with allergenic extracts	\$5

*This is for illustration purposes only. The actual amount will vary depending on your geographical location and the type of plan you choose.

Step 2

explore your options

After finding out about your needs, it's time to see what fits them. The plan information in this section explains what's available to you, why you might want it, and how it works.



HMO

How it *works*

What is an HMO?

With a Health Maintenance Organization (HMO) plan, you select a personal doctor, called a PCP, who tends to the majority of your health needs and refers you to other in-network providers if necessary.* PCP stands for “primary care physician.” A PCP is usually a general, family, or internal medicine doctor (internist), or a pediatrician.

An HMO pays benefits only when you use doctors and hospitals in the plan’s network. For covered services at in-network providers, you pay a copayment, and the plan pays the rest – so, in general, HMO plans offer low, predictable out-of-pocket costs.

To find out if your doctor participates in Humana’s network, use the “Find a doctor” link on **Humana.com**. It takes you to Physician Finder *Plus*, our online provider directory.

Why you might want an HMO

An HMO plan is a good choice for people who are willing to use certain providers in exchange for lower out-of-pocket costs.

- **Out-of-pocket costs are predictable.** An HMO generally offers lower out-of-pocket costs than PPO or fee-for-service plans. You’re only responsible for copayments, so it’s easier to predict your costs and feel secure about unexpected medical expenses.

- **You work one-on-one with your doctor.** Your PCP plays a valuable role by providing most services and, if necessary, referring you to a specialist. Your personal doctor keeps an eye on your total healthcare picture and is the point person anytime you have a health problem.
- **You have less paperwork.** Because your PCP – and other providers he or she refers you to – is in the Humana network, you don’t have to fill out claim forms.
- **Your plan provides for preventive care.** HMO plans typically include coverage for preventive care like annual check-ups, flu shots, and screenings.

HMO out-of-pocket costs

With an HMO, you’re responsible for copayments – fixed fees you pay when you see a doctor, have a prescription filled, or are admitted to the hospital. Other than your copayments, the plan pays 100 percent as long as the provider is in the network – HMOs only cover services from in-network providers. You don’t pay deductibles or coinsurance.

* See your specific plan materials for any referral requirements.

CoverageFirstSM

How it *works*

What is CoverageFirst?

With CoverageFirst, you can see any provider without a referral – but your costs are usually lower when you use in-network providers. What makes CoverageFirst unique is the \$500-per-covered member “benefit allowance” that covers many services from in-network providers before you start paying toward your deductible.

Here's how it works:

1. The plan pays the first \$500 of eligible expenses from in-network providers. You just pay a copayment, and then the plan picks up the rest. Each covered member has a separate allowance.
2. If you use the entire \$500, you pay most additional expenses until you meet the annual deductible. The plan has a separate deductible for each family member; each person's costs also apply to a deductible for the entire family. See your benefit plan document for details on your plan.
3. Once you meet the deductible, the plan starts paying coinsurance – a percentage of your costs. For example, if your coinsurance for in-network providers is 80 percent, and your services cost \$100, the plan pays \$80, and you pay \$20.
4. If the amount you pay in coinsurance during the year reaches a cap called your “out-of-pocket maximum,” the plan picks up 100 percent of your costs – other than copayments for covered services from in-network doctors and hospitals.

Like many plans, CoverageFirst has separate deductibles and out-of-pocket limits for in-network and out-of-network providers.

Why you might want CoverageFirst

CoverageFirst offers lower premiums and a “safety net” in case of a major illness or injury.

- **Your up-front costs are lower.** CoverageFirst premiums are generally lower than with other plan types.
- **You could have very low out-of-pocket costs.** Almost half of Americans – 45 percent of health plan members, according to a national study – spend less than \$500 a year on medical care.* If you're in that group, the CoverageFirst allowance might cover all of your costs except for your copayments.

- **Preventive care coverage.** Even if your \$500 is gone, CoverageFirst covers all but your copayment for preventive care office visits.
- **The out-of-pocket maximum provides peace of mind.** If you have a serious illness or injury, your costs for covered services at in-network providers are capped.

Using your allowance**

The entire \$500 is available on the first day of the plan year. You can use the allowance for:

- Doctor's office visits
- Routine outpatient laboratory tests and X-rays
- Hospital services, including semiprivate room and board, emergency room services, and outpatient surgery
- Other services such as home healthcare, physical therapy, and hospice care

Your allowance isn't depleted when you fill a prescription or receive mental health services. Also the allowance doesn't cover copayments or any services from out-of-network providers.

It's easy to keep track of how much of the \$500 you've used. After you receive care, Humana processes a claim and then sends an Explanation of Benefits – or “EOB” – that tells you how the claim was paid and how much of your allowance remains. You can also check your balance by logging in to *MyHumana* on **Humana.com**, or by calling the toll-free number on your Humana ID card.

* 2006 Reden & Anders

** Please Note: Preventive Services still apply to the PBA on SmartSuite 2004 CoverageFirst products only.

The member is responsible for copayments. Copayments and the allowance do not apply to the deductible. CoverageFirst in Arizona is insured by Humana Insurance Company.

CoverageFirstSM

How it *works*

Example 1 – Lynn (single coverage)

Lynn chooses a CoverageFirst plan with:

- \$500 allowance
- \$3,000 deductible
- 100 percent coinsurance (in-network)

Lynn goes to her primary care physician and finds out she needs some blood work.

- Doctor's office visit \$50
(Lynn pays a \$25 copayment)
- Outpatient lab \$400
(no copayment)

How Lynn uses CoverageFirst

Total cost of medical services	\$450
Lynn's copayments	\$25
CoverageFirst pays the remaining costs	\$425

Summary

Lynn's medical expenses for the calendar year didn't exceed her \$500 CoverageFirst allowance. The only medical expenses she paid were copayments totaling \$25.

Example 2 – Greg (family coverage)

Greg chooses a CoverageFirst plan.

Each covered member has a:

- \$500 allowance
- \$1,000 deductible
- 80 percent coinsurance (in-network)
- \$2,000 coinsurance maximum

Greg is injured in a fall. He has inpatient surgery and spends three days in the hospital. Later, he has a follow-up visit with a specialist.

- Physician services for hospital stay.....\$3,500
- Hospital charges\$9,000
(Greg pays \$300 in copayments – 3 days at \$100 per day)
- One specialist visit \$150
(Greg pays \$35 copayment)

How Greg uses CoverageFirst

Physician Services

Total cost of physician services for	
inpatient surgery	\$3,500
CoverageFirst pays \$500 of costs	\$500
Greg pays his deductible	\$1,000
Balance of cost of services.....	\$2,000
Plan pays 80% of balance.....	\$1,600
Greg pays coinsurance	\$400

Hospital stay

Total cost of hospital stay	\$9,000
Greg pays his hospital copayment	\$300
Health plan pays	\$8,700

Specialist visit

Total cost of specialist visit.....	\$150
Greg pays his specialist visit copayment	\$35
Plan picks up 100% of his remaining costs.....	\$115

Summary

Greg used his allowance and then paid the deductible. After that, his plan paid 80 percent of his remaining costs – other than copayments – until Greg satisfies his out-of-pocket coinsurance maximum. After Greg reaches the maximum, the plan pays 100 percent of his costs, except for copayments.

These examples are for illustration only. The amounts will vary, depending on the plan selected and the number of people covered. The member is responsible for copayments. Copayments and the allowance do not apply to the deductible. CoverageFirst in Arizona is insured by Humana Insurance Company.

* These examples may not apply to all lines of business (PPO, POS, HMO)



CoverageFirst is available on PPO, POS, and HMO lines of business. Benefits and coverages may differ by line of business. Refer to Benefit Summaries for complete benefit details.

Insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, Emphesys Insurance Company, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009 or administered by Humana Insurance Company

For Arizona Residents: Insured or administered by Humana Insurance Company

Please refer to your Benefit Plan Document (Certificate of Insurance or Summary Plan Description) for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions.

Flexible Spending Accounts are not insured benefits. Flexible Spending Accounts are a service administered by Humana Insurance Company.

Step 3



choose and use your plan

Now you're ready to roll – or enroll! This section describes the resources available to help you choose a health benefits plan. It also gives you some tips on using the plan you select.

OHIO HMO 1

Plan pays for covered services received at
PARTICIPATING providers

Preventive Care	<ul style="list-style-type: none"> Routine immunizations (<i>except for travel</i>) Routine physical exams for members age 18 and over (<i>one per year</i>) Well-child care (<i>under age 18</i>) Well-woman services Vision exam (<i>refraction limited to one per 24 months</i>) 	<p>100%</p> <p>100% after \$25 copayment per visit to primary care physician or \$30 copayment per visit to specialist</p> <p>\$30 copayment</p>
Physician Services (2)	<ul style="list-style-type: none"> Physician office visits in conjunction with an illness or injury Prenatal care (<i>office visit copayment applies to first visit only</i>) Allergy tests Allergy injections Inpatient services Outpatient services Allergy serum 	<p>100% after \$25 copayment per visit to primary care physician or \$30 copayment per visit to specialist</p> <p>100% after \$5 copayment per visit</p> <p>100%</p>
Hospital Services	<ul style="list-style-type: none"> Preadmission testing Outpatient nonsurgical care Inpatient care (<i>semiprivate room and ancillary services</i>) Outpatient surgery facility Emergency room 	<p>100%</p> <p>100% after \$200 copayment per day for first five days per admission</p> <p>100% after \$100 copayment per visit</p> <p>100% after \$200 copayment per visit (<i>copayment waived if admitted</i>)</p>
Prescription Drugs	<ul style="list-style-type: none"> Please see attached pharmacy benefit information, if applicable. 	
Other Medical Services	<ul style="list-style-type: none"> Home health care (<i>unlimited</i>) Skilled nursing facility (<i>up to 100 days per calendar year</i>) Ambulance Durable medical equipment Hospice services Radiation or respiratory therapy Physical, occupational and speech therapy (<i>up to 60 visits combined per calendar year</i>) Chiropractic care (<i>as medically necessary</i>) (<i>up to 20 visits per calendar year</i>) Diabetes services <ul style="list-style-type: none"> Diabetes education Diabetes equipment Diabetes supplies (<i>30-day supply per copayment</i>) Urgent care facility 	<p>100%</p> <p>100% after \$30 copayment per visit</p> <p>100% after \$25 copayment per visit to primary care physician or \$30 copayment per visit to specialist</p> <p>100%</p> <p>Subject to the applicable prescription drug copayment</p> <p>100% after \$35 copayment per visit</p>
Maximum Out-of-Pocket Expense Limit (<i>per calendar year</i>)	<ul style="list-style-type: none"> Individual Family 	<p>\$2,000</p> <p>\$6,000</p>
Lifetime Maximum Benefit	<ul style="list-style-type: none"> Per member benefit paid by plan 	Unlimited
Mental Health Services (1)	<ul style="list-style-type: none"> Inpatient Outpatient 	<p>100% after \$200 copayment per day for first five days per admission</p> <p>100% after \$30 copayment per visit</p>

**Alcoholism
and Chemical
Dependency Services**
(1)

- Detoxification
- Outpatient

100% after \$200 copayment per day for first five days per admission

100% after \$30 copayment per visit

Prior authorization - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at Humana.com/members/tools/ or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Only emergency services, or urgent services received while out of the service area, are covered when provided by nonparticipating providers or facilities.

Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.

- (1) Any copayment for the treatment of mental and nervous disorders or chemical dependency services do not apply to copayment expense limits.

Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing any procedure, treatment or supply. This guide is available at Humana.com/members/enrollment-center/pre-enrollment-disclosures or through your sales representative.

Copayments for any single participating provider basic health care service cannot exceed 40 percent of the average cost of providing the service to the member.

The amount of coverage provided depends upon the plan selected. Premiums will vary according to the selection made.

For general questions about the plan, contact your benefits administrator.

PRE-EXISTING CONDITION EXCLUSION

Benefits for the treatment of a pre-existing condition may be excluded.

The plan imposes a pre-existing condition exclusion. If you have a medical condition before coming to our plan, you will be required to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day

before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months) if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if

you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or 1-800-872-7207.



OHIO National POS Copayment 90/60 Plan		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Preventive Care (1)	<ul style="list-style-type: none"> Routine immunizations (except for travel) Routine Pap smear Annual routine mammogram Routine lab test and X-ray Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) 	100%	60% after deductible
	<ul style="list-style-type: none"> Routine adult physical exam (18 years and above) Routine child exams (to age 18) 	100% after office visit copayment	60% after deductible
	<ul style="list-style-type: none"> Vision exam (refraction limited to one per 24 months) 	\$40 copayment	60% after deductible
Physician Services (1)	<ul style="list-style-type: none"> Office visits Diagnostic, lab and X-rays (copayment does not apply) Allergy testing (copayment does not apply) 	100% after \$25 primary care physician/\$40 specialist copayment per visit	60% after deductible
	<ul style="list-style-type: none"> Inpatient services Outpatient services (includes surgery) Office surgery 	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> Emergency room physician visits (2) 	100%	100%
	<ul style="list-style-type: none"> Allergy injections and nonroutine injections other than allergy 	100% after \$5 copayment per visit	60% after deductible
Facility Services	<ul style="list-style-type: none"> Inpatient hospital care Outpatient surgery Outpatient nonsurgical care (does not include advanced imaging) Outpatient advanced imaging (PET, MRI, MRA, CAT, SPECT) 	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> Hospital emergency services (emergency room copayment waived if admitted) (2) 	100% after \$200 copayment per visit	100% after \$200 copayment per visit
Prescription Drugs (includes oral contraceptives)	<ul style="list-style-type: none"> Please see attached pharmacy benefit information, if applicable 		
Other Medical Services (3)	<ul style="list-style-type: none"> Skilled nursing facility (subject to 60 day limits per calendar year) Home health (unlimited) Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year) Durable medical equipment (unlimited) 	90% after deductible	60% after deductible
	<ul style="list-style-type: none"> Urgent care facility 	100% after \$75 copayment per visit	60% after deductible
	<ul style="list-style-type: none"> Chiropractic services (subject to 25 visits per calendar year) 	100% after specialist copayment per visit	60% after deductible
	<ul style="list-style-type: none"> Ambulance (2) 	90% after deductible	90% after participating deductible
	<ul style="list-style-type: none"> Transplant services 	90% after deductible (when services are received from a Humana Transplant Network provider)	60% after deductible (covered expenses are limited to a maximum benefit of \$35,000 per transplant)
Deductible and Out-of-Pocket Maximum Accumulation Methods	<ul style="list-style-type: none"> Deductible and out-of-pocket limits for participating and nonparticipating providers calculate separately 		
Deductible (per calendar year; copayments do not apply)	<ul style="list-style-type: none"> Individual 	\$500	Three times individual participating deductible
	<ul style="list-style-type: none"> Family (4) 	Two times individual participating deductible	Three times family participating deductible

National POS Copayment 90/60 Plan		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Out-of-Pocket Maximum (per calendar year; copayments apply)	• Individual	\$2,000	Three times individual participating out-of-pocket maximum
	• Family	Two times individual participating out-of-pocket maximum	Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit		Unlimited (participating and nonparticipating combined)	
Behavioral Health (mental health and substance abuse) (5)	• Inpatient services	Same as inpatient hospital care	60% after deductible
	• Outpatient therapy sessions	100% after specialist office visit copayment	60% after deductible

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Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable deductible, coinsurance, or copayment.

Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

Primary care and specialist physicians and other providers in Humana's networks are not the agents, employees or partners of Humana or any of its affiliates or subsidiaries. They are independent contractors. Humana is not a provider of medical services. Humana does not endorse or control the clinical judgment or treatment recommendations made by the physicians or other providers listed in network directories or otherwise selected by you.

To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.

- (1) The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.
- (2) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
- (3) Visit and day limits are combined for participating and nonparticipating providers.

- (4) You are not required to meet individual deductibles once the family deductible has been met.
- (5) Biologically-based mental illness (BMI) is covered same as any other illness.

Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing any procedure, treatment or supply. This guide is available at Humana.com/members/enrollment-center/ pre-enrollment disclosures or through your sales representative.

The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

For general questions about the plan, contact your benefits administrator.

PRE-EXISTING CONDITION EXCLUSION

Benefits for the treatment of a pre-existing condition may be excluded.

The plan imposes a pre-existing condition exclusion. If you have a medical condition before coming to our plan, you will be required to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day

before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy; genetic information in the absence of a diagnosis of the condition related to the information; or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months) if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage". Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if

you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Humana Enrollment at 2432 Fortune Drive, Lexington, KY 40509 or 1-800-872-7207.

HUMANA
Guidance when you need it most

OHIO National POS CoverageFirst Coinsurance 80/50 Plan

Plan pays for services at
PARTICIPATING providers

Plan pays for services at
NONPARTICIPATING providers

Up-front Benefit Allowance	<ul style="list-style-type: none"> Annual member <i>benefit</i> (Applies to medical services received from participating providers only. Preventive and pharmacy do not apply. Does not apply to member copayments.) 	\$500 per calendar year per member	Not applicable
Annual Deductible (per calendar year; copayments do not apply)	<ul style="list-style-type: none"> Individual Family (1) 	\$1,000 Two times individual participating deductible	Three times individual participating deductible Three times family participating deductible
Preventive Care (Does not reduce the benefit allowance)	<ul style="list-style-type: none"> Annual routine adult physical exam (18 years and above) Routine child care (up to age 18) Routine immunizations (except for travel) Routine mammography and Pap smears Routine outpatient laboratory tests/X-rays Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) Vision exam (refraction limited to one per 24 months) 	100% after office visit copayment (2) 100% \$35 copayment	50% after deductible 50% after deductible
Physician Services (2)	<ul style="list-style-type: none"> Office visits (excludes diagnostic lab and X-ray) Prenatal benefit (office visit copayment applies to first visit only) Allergy testing (covered as part of office visit) Physician visits to emergency room (3) Diagnostic tests, lab and X-rays (when done in office by physician) Allergy serum Inpatient services Outpatient services Allergy injections and nonroutine injections other than allergy 	100% after \$20 primary care physician/\$35 specialist copayment per visit 100% 100% 80% after deductible 100% after \$5 copayment per visit	50% after deductible 100% 50% after deductible 50% after deductible 50% after deductible
Hospital Services	<ul style="list-style-type: none"> Inpatient care (semiprivate room and board, nursing care, ICU) Outpatient surgery – facility Outpatient nonsurgical care Emergency room visit (copayment is waived if admitted) (3) 	80% after deductible 100% after \$200 copayment per visit	50% after deductible 100% after \$200 copayment per visit
Prescription Drugs	<ul style="list-style-type: none"> Please see attached pharmacy benefit information, if applicable 		
Other Medical Services (4)	<ul style="list-style-type: none"> Skilled nursing facility (up to 60 days per calendar year) Home health care (unlimited) Durable medical equipment (unlimited) Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year) Ambulance (3) Chiropractic (25 visits per calendar year) Transplant services 	80% after deductible 80% after deductible Same as specialist copayment 80% after deductible (when services are received from a Humana Transplant Network Provider)	50% after deductible 80% after participating deductible 50% after deductible 50% after participating deductible (covered expenses are limited to a maximum benefit of \$35,000 per organ transplant)

National POS CoverageFirst Coinsurance 80/50 Plan

Plan pays for services at
PARTICIPATING providers

Plan pays for services at
NONPARTICIPATING providers

Behavioral Health (mental/chemical/alcohol combined) (4)	<ul style="list-style-type: none"> Inpatient services (limited to 30 days per calendar year) Outpatient therapy sessions (limited to 20 days per calendar year) 	Same as any other covered condition	Same as any other covered condition
Maximum Out-Of-Pocket Expense Limit (per calendar year; excludes deductibles)	<ul style="list-style-type: none"> Individual Family 	\$2,000	Three times individual participating out-of-pocket maximum
Lifetime Maximum Benefit			Unlimited (participating and nonparticipating combined)

Prior authorization - Humana sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. Humana does this solely to determine whether the service or procedure qualifies for payment under your benefit plan. You and your health care provider decide whether you should have such services or procedures. Humana's preauthorization determination relates solely to payment by Humana. To find a list of services and supplies that require preauthorization for coverage, please visit our Website at [Humana.com/members/tools/](https://www.humana.com/members/tools/) or call Customer Service.

Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. Your health care practitioner should call Customer Service to obtain preauthorization.

Payments - Participating providers agree to accept amounts negotiated with Humana as payment in full. The member is responsible for any required deductible, coinsurance, or other copayments. Plan benefits paid to nonparticipating providers are based on maximum allowable fees, as defined in your Certificate of Insurance.

Nonparticipating providers may balance bill you for charges in excess of the maximum allowable fee. You will be responsible for charges in excess of the maximum allowable fee in addition to any applicable

deductible, coinsurance, or copayment. Additionally, any amount you pay the provider in excess of the maximum allowable fee will not apply to your out-of-pocket limit or deductible.

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To be covered, expenses must be medically necessary and specified as covered. Please see your Certificate for more information on medical necessity and other specific plan benefits.

- (1) You are not required to meet individual deductibles once the family deductible has been met.
- (2) Copayments for visits to primary care physicians, as defined in the plan, are generally lower than for visits to specialists. The following are generally defined as primary care physicians under your plan: general practitioner, family practitioner, pediatrician or internist.

- (3) Ambulance transportation and/or services received in an emergency room are not covered unless required because of emergency care, as defined in your Certificate.
- (4) Visit and day limits are combined for participating and nonparticipating providers. Biologically-based mental illness (BMI) is covered same as any other illness.

Before applying for coverage, please refer to the Regulatory Pre-enrollment Disclosure Guide for a description of plan provisions which may exclude, limit, reduce, modify or terminate your coverage. Limitations and exclusions to coverage apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing any procedure, treatment or supply. This guide is available at [Humana.com/members/enrollment-center/pre-enrollment-disclosures](https://www.humana.com/members/enrollment-center/pre-enrollment-disclosures) or through your sales representative.

The amount of benefit provided depends upon the plan selected. Premiums will vary according to the selection made.

For general questions about the plan, contact your benefits administrator.

Limitations and Exclusions

This is a partial list of limitations and exclusions. Your group may have specific limitations and exclusions not included on this list. Please check your Group Plan/Certificate of Coverage for this complete listing. The Group Plan/Certificate of Coverage is the document upon which benefit payment will be determined.

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

1. Treatments, services, supplies or surgeries that are not medically necessary, except for the specified preventive services as outlined in the "Schedule of Benefits" and described in the "Covered Expenses" section of this Certificate.
2. A sickness or bodily injury arising out of, or in the course of, any employment for wage, gain or profit.
3. A sickness or bodily injury that is covered under any Workers' Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers' Compensation and lawfully chose not to be.
4. Services provided to you, if you do not comply with the master group contract's requirements. These include services:
 - a. not provided by a network provider, unless required for emergency care; (Unless specifically stated on this benefit summary.)
 - b. received in an emergency room, unless required because of emergency care;
 - c. which require preauthorization if preauthorization was not obtained.
 - d. which require a primary care physician referral if a referral was not obtained. (Unless specifically stated on this benefit summary.)
5. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
6. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.

7. Prescription drugs and self-administered injectable drugs unless administered to you:
 - a. while an inpatient in a hospital, skilled nursing facility, or health care treatment facility;
 - b. by a health care practitioner during an office visit; or
 - c. by a home health care agency as part of a covered home health care plan when approved by us.
8. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
9. In-vitro fertilization; infertility services that are not medically necessary to diagnose or correct the disease of the reproductive organs, including but not limited to, gamete intrafallopian tube transfer (GIFT) and zygote intrafallopian transfer (ZIFT); sex change services; or reversal of elective sterilization.
10. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
 - a. resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
 - b. resulting from congenital disease or anomaly of a covered dependent child which resulted in a functional impairment.

A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.
11. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery or periodontic surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and treatment related to the preparation of or fitting of dentures, and any dental services related to a bodily injury or sickness unless otherwise stated in this Certificate.

12. Custodial care and maintenance care.
13. Any treatment, including but not limited to surgical procedures:
 - a. for obesity, which includes morbid obesity; or
 - b. for obesity, which includes morbid obesity, for the purpose of treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity.
14. Alternative medicine.
15. Chiropractic services or spinal manipulations.
16. Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an accident or following cataract surgery as stated in this Certificate), vision training, biomicroscopy, field charting, or aniseikonic investigation.
17. Expenses for treatment of complications of non-covered procedures or services.
18. Any care, treatment, services, equipment or supplies received outside of the service area:
 - a. if you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
 - b. which are not authorized by us or to the extent they exceed the maximum allowable fee.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing the procedure, treatment or supply; however, the procedure, treatment or supply will not be a covered expense.

HUMANA
Guidance when you need it most

OHIO National POS CoverageFirst Coinsurance 100/70 Plan		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Up-front Benefit Allowance	<ul style="list-style-type: none"> Annual member <i>benefit</i> (Applies to medical services received from participating providers only. Preventive and pharmacy do not apply. Does not apply to member copayments.) 	\$500 per calendar year per member	Not applicable
Annual Deductible (per calendar year; copayments do not apply)	<ul style="list-style-type: none"> Individual Family (1) 	\$2,500 Two times individual participating deductible	Three times individual participating deductible Three times family participating deductible
Preventive Care (Does not reduce the benefit allowance)	<ul style="list-style-type: none"> Annual routine adult physical exam (18 years and above) Routine child care (up to age 18) Routine immunizations (except for travel) Routine mammography and Pap smears Routine outpatient laboratory tests/X-rays Preventive endoscopy (includes colonoscopy, proctosigmoidoscopy and sigmoidoscopy) Vision exam (refraction limited to one per 24 months) 	100% after office visit copayment (2) 100% \$40 copayment	70% after deductible 70% after deductible
Physician Services (2)	<ul style="list-style-type: none"> Office visits (excludes diagnostic lab and X-ray) Prenatal benefit (office visit copayment applies to first visit only) Allergy testing (covered as part of office visit) Physician visits to emergency room (3) Diagnostic tests, lab and X-rays (when done in office by physician) Allergy serum Inpatient services Outpatient services Allergy injections and nonroutine injections other than allergy 	100% after \$25 primary care physician/\$40 specialist copayment per visit 100% 100% after deductible 100% after \$5 copayment per visit	70% after deductible 100% 70% after deductible 70% after deductible
Hospital Services	<ul style="list-style-type: none"> Inpatient care (semiprivate room and board, nursing care, ICU) Outpatient surgery – facility Outpatient nonsurgical care Emergency room visit (copayment is waived if admitted) (3) 	100% after deductible 100% after \$200 copayment per visit	70% after deductible 100% after \$200 copayment per visit
Prescription Drugs	<ul style="list-style-type: none"> Please see attached pharmacy benefit information, if applicable 		
Other Medical Services (4)	<ul style="list-style-type: none"> Skilled nursing facility (up to 60 days per calendar year) Home health care (unlimited) Durable medical equipment (unlimited) Physical, occupational, cognitive, speech and hearing therapy (subject to combined limit for all therapy services up to 60 visits per calendar year) Ambulance (3) Chiropractic (25 visits per calendar year) Transplant services 	100% after deductible Same as specialist copayment 100% after deductible (when services are received from a Humana Transplant Network Provider)	70% after deductible 100% after participating deductible 70% after deductible 70% after participating deductible (covered expenses are limited to a maximum benefit of \$35,000 per organ transplant)

National POS CoverageFirst Coinsurance 100/70 Plan

		Plan pays for services at PARTICIPATING providers	Plan pays for services at NONPARTICIPATING providers
Behavioral Health (mental/chemical/alcohol combined) (4)	<ul style="list-style-type: none"> Inpatient services (limited to 30 days per calendar year) Outpatient therapy sessions (limited to 20 days per calendar year) 	Same as any other covered condition	Same as any other covered condition
Maximum Out-Of-Pocket Expense Limit (per calendar year; excludes deductibles)	<ul style="list-style-type: none"> Individual Family 	\$2,000 Two times individual participating out-of-pocket maximum	Three times individual participating out-of-pocket maximum Three times family participating out-of-pocket maximum
Lifetime Maximum Benefit	Unlimited (participating and nonparticipating combined)		

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3. A sickness or bodily injury that is covered under any Workers' Compensation or similar law. This limitation also applies to a covered person who is not covered by Workers' Compensation and lawfully chose not to be.
4. Services provided to you, if you do not comply with the master group contract's requirements. These include services:
 - a. not provided by a network provider, unless required for emergency care; (Unless specifically stated on this benefit summary.)
 - b. received in an emergency room, unless required because of emergency care;
 - c. which require preauthorization if preauthorization was not obtained.
 - d. which require a primary care physician referral if a referral was not obtained. (Unless specifically stated on this benefit summary.)
5. Any drug, biological product, device, medical treatment, or procedure which is experimental, or investigational or for research purposes.
6. Treatment of nicotine habit or addiction, including, but not limited to, nicotine patches, hypnosis, smoking cessation classes or tapes.
7. Prescription drugs and self-administered injectable drugs unless administered to you:
 - a. while an inpatient in a hospital, skilled nursing facility, or health care treatment facility;
 - b. by a health care practitioner during an office visit; or
 - c. by a home health care agency as part of a covered home health care plan when approved by us.
8. Hearing aids, the fitting of hearing aids or advice on their care; implantable hearing devices.
9. In-vitro fertilization; infertility services that are not medically necessary to diagnose or correct the disease of the reproductive organs, including but not limited to, gamete intrafallopian tube transfer (GIFT) and zygote intrafallopian transfer (ZIFT); sex change services; or reversal of elective sterilization.
10. Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery:
 - a. resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or
 - b. resulting from congenital disease or anomaly of a covered dependent child which resulted in a functional impairment.

A functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition are not covered, unless the condition(s) described above are also met.
11. Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery or periodontic surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and treatment related to the preparation of or fitting of dentures, and any dental services related to a bodily injury or sickness unless otherwise stated in this Certificate.
12. Custodial care and maintenance care.
13. Any treatment, including but not limited to surgical procedures:
 - a. for obesity, which includes morbid obesity; or
 - b. for obesity, which includes morbid obesity, for the purpose of treating a sickness or bodily injury caused by, complicated by, or exacerbated by the obesity.
14. Alternative medicine.
15. Chiropractic services or spinal manipulations.
16. Vision examinations or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; or, the purchase or fitting of eyeglasses or contact lenses (except as the result of an accident or following cataract surgery as stated in this Certificate), vision training, biomicroscopy, field charting, or aniseikonic investigation.
17. Expenses for treatment of complications of non-covered procedures or services.
18. Any care, treatment, services, equipment or supplies received outside of the service area:
 - a. if you could have reasonably foreseen or anticipated their need prior to departure from the service area; and
 - b. which are not authorized by us or to the extent they exceed the maximum allowable fee.

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, treatment or supply. This does not prevent your health care practitioner from providing or performing the procedure, treatment or supply; however, the procedure, treatment or supply will not be a covered expense.

HUMANA
Guidance when you need it most

Rx Benefits

overview and **drug** lists

This section includes a brief overview of the Humana prescription drug benefits your employer offers, as well as Humana's Drug List. The materials explain how Humana's Rx benefits work and offer tips that can help you save money.



How the Rx4 structure works

Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts. The levels are organized as follows:

- **Level One:** lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four:** highest copayment for high-technology drugs (certain brand-name drugs, biotechnology drugs and self-administered injectable medications).
- If you request a brand-name drug when a generic equivalent is available, you pay the applicable generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing "Dispense as Written" on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a "Dispense as Written" prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee, which is composed of physicians and pharmacists. Drugs are reviewed for safety, effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level are subject to change throughout the year. If drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your doctor to determine appropriateness or clinical effectiveness.

Some drugs in all levels may be subject to dispensing limitations, based on age, gender, duration or quantity. Additionally, some drugs may need prior authorization in order to be covered. In these cases, your physician should contact Humana Clinical Pharmacy Review at 1-800-555-CLIN (2546).

Members can visit Humana's Website, **Humana.com**, to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana's Customer Service with questions or to request a partial Humana Rx4 Drug List by mail.

Coverage at participating pharmacies

When you present your membership card at a participating pharmacy, you are required to make a copayment for each prescription based on the current assigned level of the drug.

Drugs assigned to:	Copayment per prescription or refill
Level One:	\$15
Level Two:	\$30
Level Three:	\$50
Level Four:	25%* of the total required payment to the dispensing pharmacy per prescription or refill to a maximum of \$250 per script.

* The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to \$2,500 per calendar year, per member.

- If the dispensing pharmacy's charge is less than the corresponding copayment, you will only be responsible for the lower amount.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.

There are no claim forms to file if you use a participating pharmacy and present your membership card with each prescription.

Nonparticipating pharmacy coverage*

You may also purchase prescribed medications from a nonparticipating pharmacy. You will be required to pay for your prescriptions according to the following rule.

- You pay 100 percent of the dispensing pharmacy's charges.
 - You file a claim form with Humana (address is on the back of ID card).
 - Claim is paid at 70 percent of the dispensing pharmacy's charges, after they are first reduced by the applicable copayment.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.
- * In Georgia, the nonparticipating benefits are paid the same as the participating benefits, per state regulation.

Coverage specifics

Your coverage includes the following:

- A 30-day supply or the amount prescribed, whichever is less, for each prescription or refill.
- Contraceptives.
- For Arizona, coverage also includes FDA approved contraceptive devices.
- Certain self-administered injectable drugs and related supplies approved by Humana.
- Certain drugs, medicines or medications that, under federal or state law, may be dispensed only by prescription from a physician.

Some drugs may be subject to prior authorization requirements for coverage under the plan. Additionally, some drugs may have dispensing limitations, which limit coverage based on duration, age, gender or dosage criteria. To determine whether a drug prescribed for you may be affected by these coverage limitations, please contact Customer Service or visit our Website.

For a complete listing of participating pharmacies, please refer to your participating provider directory, or visit our Website at **Humana.com**

Mail-order and 90-day Retail

For your convenience, you can receive a maximum 90-day supply per prescription or refill (maximum 30-day supply for self-administered injectable and specialty drugs) for certain maintenance drugs. In these cases, multiple copayments will usually apply. The same requirements apply whether purchasing medications through a participating mail-order pharmacy or purchasing in person at a retail pharmacy. Some retail pharmacies may not dispense on a 90-day basis. Members can call Customer Service or visit our Website for more information, including mail-order forms.

Definition of terms

- Brand-name medication (drug): a medication that is manufactured and distributed by only one pharmaceutical manufacturer or as defined by the national pricing standard used by Humana.
- Copayment: the amount to be paid by the member toward the cost of each separate prescription or refill of a covered drug when dispensed by a pharmacy.
- Generic medication (drug): a medication that is manufactured, distributed, and available from several pharmaceutical manufacturers and identified by the chemical name or as defined by the national pricing standard used by Humana.
- Participating pharmacy: a pharmacy that has signed a direct agreement with us or has been designated by us to provide covered pharmacy services, covered specialty pharmacy services; or covered mail order pharmacy services, as defined by us, to covered persons, including covered prescriptions or refills delivered through the mail.
- Nonparticipating pharmacy: a pharmacy that has not been designated by us to provide services to covered persons.

Limitations and exclusions

Unless specifically stated otherwise, no benefits will be provided for or on account of the following items:

- Any drug prescribed for a sickness or bodily injury not covered under the master group contract or policy.
- Any drug, medicine or medication labeled "Caution-limited by federal law to investigational use" or any experimental or investigational drug, medicine or medication, even though a charge is made to you.
- Anorectic or any drug used for the purpose of weight control.
- Any drug used for cosmetic purposes, including but not limited to:
 - Tretinoin, e.g. Retin A, except if you are under the age of 45 or are diagnosed as having adult acne;
 - Dermatologicals or hair growth stimulants; or
 - Pigmenting or de-pigmenting agents, e.g. Solaquin.
- Any drug or medicine that is:
 - Lawfully obtainable without a prescription (over the counter drugs), except insulin; or
 - Available in prescription strength without a prescription.
- Abortifacients (drugs used to induce abortions).
- Medications for infertility services.
- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra.
- Any drug for which prior authorization is required, as determined by us, and not obtained.

Limitations and exclusions (*cont'd*)

- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications.
- Treatment for onychomycosis (nail fungus).
- Any portion of a prescription or refill that exceeds a 90-day supply, received from a mail order pharmacy or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill.
- Any portion of a prescription or refill that exceeds a 30-day supply, received from a retail pharmacy that does not participate in our program which allows you to receive a 90-day supply of a prescription or refill.
- Any portion of a specialty drug or self-administered injectable drug received from a retail pharmacy or a specialty pharmacy that exceeds a 30-day supply, unless otherwise determined by us.
- Legend drugs which are not deemed medically necessary by us.
- Prescriptions filled at a non-network pharmacy except for prescriptions required during an emergency.
- More than one prescription or refill for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75% of the previous prescription or refill, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, or a retail pharmacy that participates in our program which allows you to receive a 90-day supply of a prescription or refill, in which case you have used, or should have used 66% of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner.)

These limitations and exclusions apply even if a health care practitioner has performed or prescribed a medically appropriate procedure, service, treatment, supply or prescription. This does not prevent your health care practitioner or pharmacist from providing or performing the procedure, service, treatment, supply or prescription; however, the procedure, service, treatment, supply or prescription will not be a covered expense.

This is only a partial list of limitations and exclusions. Please refer to the Certificate of Coverage/Insurance for complete details regarding prescription drug coverage.



Offered by Humana Health Inc. and Humana Insurance Company

Please refer to your Certificate of Coverage for more information on the company providing your benefits.

HumanaPOS

Rx4

How it *works*

What is Rx4?

Rx4 puts drugs in one of four levels based on how much they cost. For each level, you pay a specific copayment. Generally, your copayment is lower for drugs that cost less and higher for more expensive drugs. No matter which level your drug is in, the drug is covered at least in part.

How Rx4 works

With an Rx4 plan, you pay a copayment to the pharmacy when you fill a prescription. The copayment is based on the level of the drug:

- Level One: Low-cost generic and brand-name drugs.
- Level Two: Higher-cost generic and brand-name drugs.
- Level Three: Higher-cost drugs, mostly brand names. These drugs may have generic or brand-name alternatives on Levels One or Two that may save you money. This level also includes some self-administered injectable medications.
- Level Four: Expensive drugs. This level includes self-administered injectable medications and high-technology drugs that are often newly approved by the U.S. Food and Drug Administration.

Your employer chooses the copayment amounts for your plan. For the first three levels, your copayment is a set amount – for example, \$10 for Level One, \$25 for Level Two, and \$50 for Level Three. For Level Four drugs, you pay a percentage of the cost – for example, 25 percent of the retail cost. Your plan pays for the rest of the prescription.

For more information, go to **Humana.com** and select “Prescription Drug” from the “Find a” section on the left side of the page. You can also look up the level for a specific drug, view retail costs for drugs, and find possible alternatives.

How it works example

Let’s say your copayment amounts are \$10/\$25/\$50/25% and you fill a prescription for Albuterol, a generic asthma medication. The retail cost for Albuterol is \$15.60. Because it’s in Level One, you pay a \$10 copayment, and the plan picks up the remaining \$5.60.

Take advantage of *RightSource*SM mail-order

Humana’s mail-order prescription service offers several advantages:

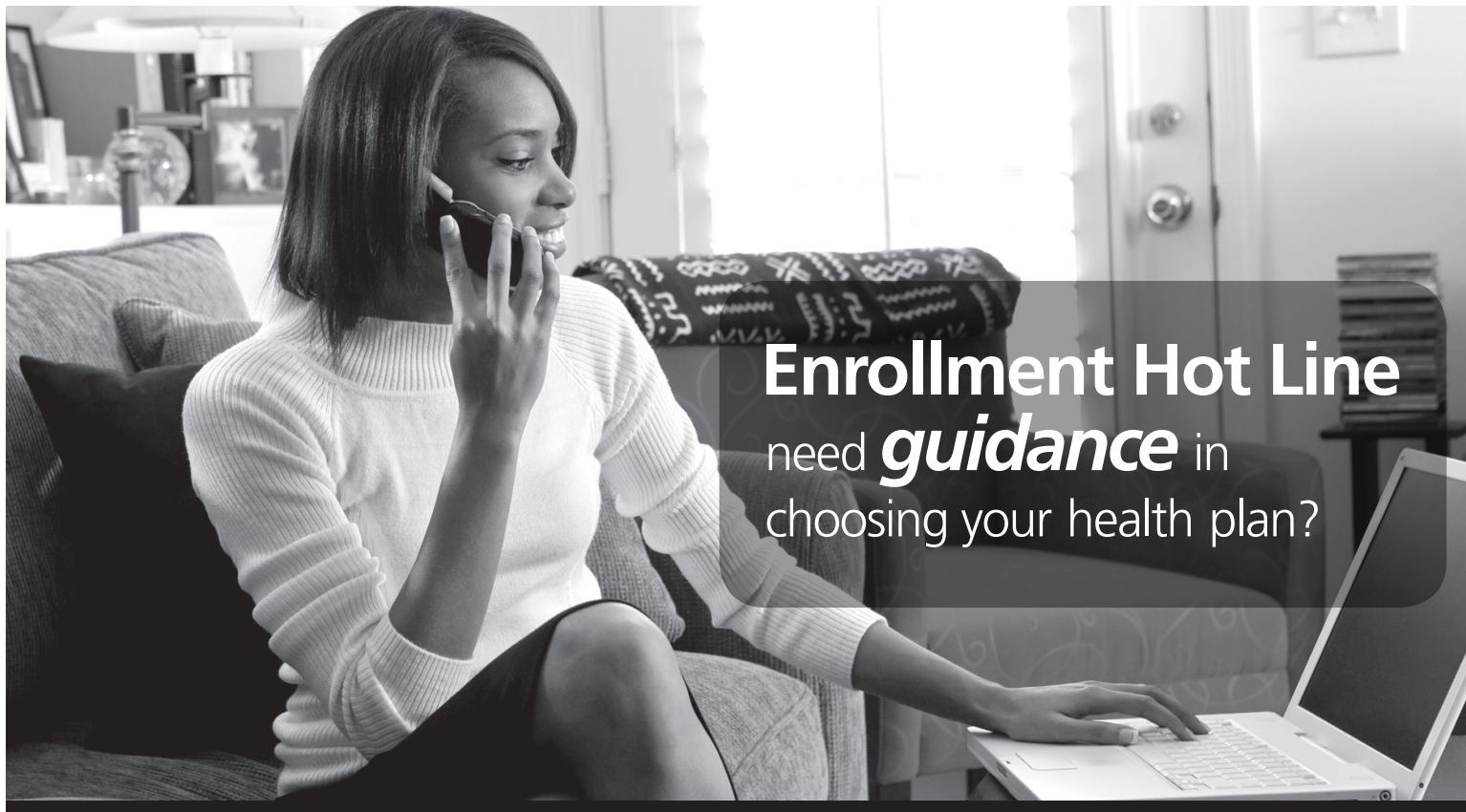
- Convenience – no need to run to the pharmacy every time you need a prescription refilled, and you can receive a 90-day supply with each order.
- Savings – with generic alternatives and 90-day discounts, *RightSource* may reduce your drug costs.
- Service – You can speak directly to a pharmacist whenever you need help – and *RightSource* will give you a call when your order is received and shipped.

Find out more at **www.humana.com/rightsource**.

Other ways to save money with Rx4

To save money on the Rx4 plan:

- Talk to your doctor about generic equivalents or alternative medications.
- Use in-network pharmacies so you can take advantage of reduced prices for Humana members – which is especially important when you pay a percentage of the drug’s cost.



Enrollment Hot Line
need ***guidance*** in
choosing your health plan?

Humana has you covered ... in more ways than one.

Call us toll-free for answers to questions about your Humana health plan and benefits, for help enrolling, and to find out about additional resources available to Humana members.

1-888-393-6765

January - September:

8 a.m. to 7 p.m., Eastern time, Monday through Friday

October - December:

8 a.m. to 8 p.m., Eastern time, Monday through Friday

If you prefer, e-mail questions to:

oe@humana.com.

HUMANA.
Guidance when you need it most

Savings Center:

One more reason to **choose** Humana

The Savings Center is a great place to find ways to lower the cost of staying healthy. Take advantage of these Humana member discounts as often as you like:

Vision discount programs

- **EyeMed – 1-866-392-6056**

Discounts on routine exams, eyeglass frames and lenses – including a wide range of lens options – contact lenses, and laser correction.

To receive your EyeMed discount:

- Visit Physician Finder Plus on **Humana.com** to locate an EyeMed Vision provider near you
- Tell the EyeMed provider you're a Humana member with EyeMed Vision benefits
- Print the discount ID card – you'll find a link on the EyeMed, TruVision, and Alternative Medicine pages – or present your Humana medical or dental ID card to your EyeMed provider

Your EyeMed provider will apply the discount directly to your purchase.

- **TruVision – 1-877-580-2020**

Traditional and custom LASIK to correct problems such as nearsightedness, farsightedness, and astigmatism, offered at more than 200 TruVision centers nationwide for less than \$1,000 per eye. Services include:

- Telephone screening
- Comprehensive eye exam
- LASIK procedure on an FDA-approved excimer laser
- Postoperative care
- Retreatment warranty

To schedule an exam, determine price, find a location in your area, or get more information, call a Customer Care specialist at **1-877-580-2020**.

Complementary and Alternative Medicine (CAM) discount program*

- Provided by The American WholeHealth (AWH) Network, with more than 25,000 practitioners
To access CAM services:
- Select a provider through the Health & Wellness link of the Savings Center or call the Customer Care number on your member ID
- Present the Humana discount card below to receive the specified discount

It's that easy!

You don't need a referral to visit a participating massage therapist, acupuncturist, or chiropractor. However, some Humana health plans offer coverage for some CAM services, so use your insured benefits whenever possible.

*Not available in Arkansas, Tennessee, Oklahoma and where prohibited by law.

Medication Savings

- Save on over-the-counter (OTC) medications for a wide range of conditions
- Visit the drug coverage search to find alternatives and compare estimated costs for your prescriptions
- Sign up for RightSourceRxSM to get your prescriptions by mail and save time and money

Stretch your health care dollars

Get special discounts just for Humana members on a wide variety of products and programs, from fitness facilities and weight management programs to tobacco cessation and herbal teas and supplements. Check out the Health & Wellness link for a complete list.



These discount programs are not part of your insurance product. Discounts are only available at participating providers. Service providers are solely responsible for the provision of products and services. Humana and its affiliates are not liable for product defects, provider negligence or other errors in the delivery of discount products or services. The insured/administered benefits that make these discount services available are offered by Humana Medical Plan, Inc., Humana Employers Health Plan of Georgia, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Health Plan of Ohio, Inc., Humana Health Plans of Puerto Rico, Inc. License # 00235-0008, Humana Wisconsin Health Organization Insurance Corporation, or Humana Health Plan of Texas, Inc. – A Health Maintenance Organization or insured by Humana Health Insurance Company of Florida, Inc., Humana Health Plan, Inc., Humana Health Benefit Plan of Louisiana, Inc., Humana Insurance Company, Humana Insurance Company of Kentucky, or Humana Insurance of Puerto Rico, Inc. License # 00187-0009 or administered by Humana Insurance Company.

For Arizona Residents: Offered by Humana Health Plan, Inc. or insured or administered by Humana Insurance Company.

Please refer to your Certificate of Coverage/Insurance or Summary Plan Description for more information on the company providing your benefits.

Our health benefit plans have limitations and exclusions.

Online Enrollment

a quick *overview*

Humana's online enrollment experience makes enrolling in your benefits quick and easy. Here's an overview of what to expect:

Log-in

Log in is easy. Go to **Humana.com** and click on "Enrollment Center" under Member Links. Click on "Enroll Now" under Group Health Enrollment Center. If you're currently a Humana member -- and registered for MyHumana, your secure Website -- log into the Enrollment Center by using your MyHumana user name and password. Or, if you're not registered for MyHumana, use your Social Security number, birth date, and ZIP code to log in.

Enrollment home page

A personalized welcome page gives you several enrollment options, depending on what benefits you're eligible to enroll in.

Your information pages

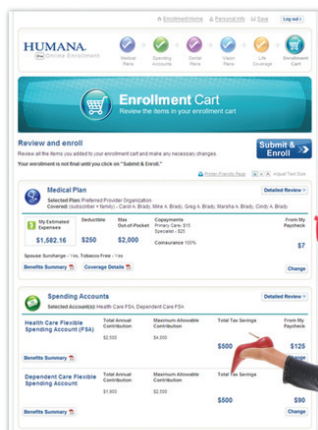
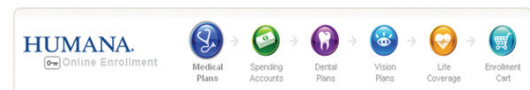
You'll review a "Contact" page with your address and other personal information, as well as dependent choices -- with the opportunity to make changes. There's also a page called "My Communication Preferences" where you can give Humana your e-mail address and tell us how you want to receive communications from us.

Color coding

Different colors for each product choice -- and coordinating icons -- let you choose the section you want and inform you about where you are in the Enrollment Center.

Automatic progression to each section

When you finish one section, you'll automatically move on to the next, so you'll never wonder where to go next.



Shopping cart feature

Put your plan selections into a shopping cart as you make decisions, then "check out" in the end with an "Enroll & Submit" button. If you have to leave the Enrollment Center and return later or another day, it's easy to do and all your selections are saved.



HUMANA
Guidance when you need it most

Decision-making tools

If you're enrolling in a medical plan, decision-making tools include a look at the plan that's **"Closest to My Current Plan,"** and give you access to a detailed comparison of plans. A **Detailed Comparison** is available to review up to three plans. By answering some financial questions, you can also get help with **"My Estimated Expenses."** If you're already a Humana member and wondering about the details of **"My Current Plan,"** you can find out. You can also read about how **"Types of Medical Plans"** differ and compare with each other. Finally, there's a **"Glossary"** so you can look up unfamiliar terms. These tools are designed to help you make the best choices while enrolling.

Multiple chances to change your mind

Each section has buttons to let you go back and make changes. This includes the final step – the Enrollment Cart – where you can still make changes if you want. And, if you haven't made all the choices your employer requires, you'll get a message to return to the uncompleted section to select or waive coverage.

Spending account help

If you're eligible for a spending account, you can click on a calculator to help you estimate your expenses.

Registration for MyHumana

Your final confirmation page gives you the opportunity to enroll in MyHumana, your secure Website on **Humana.com** that provides all the information you need to know throughout the year about your benefits.

The screenshot displays the MyHumana website interface. At the top, there's a navigation bar with links like 'MyHumana', 'Plans & Coverage', 'Claims & Spending', and 'Health & Wellness'. A prominent banner reads 'Fight the flu' with a subtext 'Find out how you can protect yourself from getting sick during 2010'. Below this, a section titled 'Access: The information you need fast' offers links to 'Messages', 'Claims Information', and 'Plan Information'. A sidebar on the left lists 'Recommended' links such as 'Your Information', 'Spending Accounts', 'Health & Wellness', and 'Plans & Coverage'. The main content area features a 'Congratulations!' message stating 'You've successfully enrolled - now sign up for MyHumana'. It includes a 'Print your enrollment summary for your records' section and a 'Register for MyHumana' section with a form for creating a new account. The form fields include 'Create Your User ID', 'Create Your Password', 'Re-type Your Password', 'Email', 'Social Security Number', 'Answer for Security Question', 'Authentication Number', and 'Type Text from Above Image'. A 'Create Account' button is at the bottom right of the form.

HUMANA
Guidance when you need it most